

BREAST PUMP ORDER REQUEST (A.C.A.)

Ship to: ☐ Home ☐ Clinic

PATIENT INFORMATION:

Patient Name: _____ Phone: _____
Ship to Address: _____ Apt: _____
City: _____ State: _____ Zip: _____
Insurance (attach copy): ☐ Anthem Blue Cross ☐ Premera BC ☐ LifeWise HP ID#: _____
DOB: _____ EDD / Delivery Date: _____

The Affordable Care Act (ACA) requires health plans to cover breast pumps without cost-sharing as preventive services.


DIAGNOSIS (Dx): ☐ Postpartum care, lactation V24.1

ITEM ORDERED:

1 - Electric Breast Pump (E0603NU) **MAKE/MODEL*:** ☐ MEDELA Personal Double Electric Pump ☐ EVENFLO Double Electric Pump

*Upgrade to premium models like the Medela Pump In Style Advanced and Freestyle are available, call/text (909) 569-9013 for details

ASSIGNMENT OF BENEFITS: The undersigned hereby authorizes Advanced Home Medical Inc to request on my/our behalf and to collect directly all public and private insurance benefits due to products supplied patient by Advanced Home Medical Inc. In the event payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to Advanced Home Medical Inc all checks for such payment. The undersigned understands that any upgrade fee is solely her responsibility and is NOT reimbursable by her insurance. The undersigned certifies that she has not received a personal use electric breastpump (E0603) within the past year.

Patient Signature 

Date: _____

DECLARATION: I certify that this is true for the above patient. I have completely reviewed my patient's medical records and the items ordered. I understand that any falsification, omission, concealment of material fact may be subject to civil or criminal liability.

Provider Signature 

Date: _____

Provider Name & Address:

Name: _____ NPI: _____
Facility/Clinic: _____
Address: _____ Suite: _____
City: _____ State: _____ Zip: _____
Contact: _____ Phone: _____

PLEASE FAX TO:
1-888-518-7568
or email to:
info@advancedhomemed.com

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